

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041013

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

317

Primary Registration District No.

590

Registrar's No.

3007

FILED OCT 26 1962

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH  
a. COUNTY *St. Louis*

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN *Pagedale*

Length of stay in lb  
*YRS.*

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION *6740 Roberts Ave*

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE *Missouri* b. COUNTY *St. Louis*

c. CITY OR TOWN *Pagedale*

Inside Limits  
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)  
*6740 Roberts Avenue*

Reside on Farm  
Yes ☐ No ☒

3. NAME OF DECEASED  
(Type or print)

First Middle Last  
*Birdie Esther Fox*

4. DATE OF DEATH

Month Day Year  
*October 17, 1962*

5. SEX  
*Female*

6. COLOR OR RACE  
*White*

7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐

8. DATE OF BIRTH  
*7/20/89*

9. AGE (last birthday)  
*73*

IF UNDER 1 YEAR  
Months Days

IF UNDER 24 HR  
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Garment Seamstress*

10b. KIND OF BUSINESS OR INDUSTRY  
*Retired 8 years*

11. BIRTHPLACE (City and state or country)  
*Charleston, Missouri*

12. CITIZEN OF WHAT COUNTRY  
*U.S.A.*

13a. FATHER'S NAME

*John Stires*

13b. MOTHER'S MAIDEN NAME

*Lina Sigler*

14. NAME OF HUSBAND OR WIFE

*Richard Fox*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)  
*no none*

16. SOCIAL SECURITY NO.

17. INFORMANT Address  
*Robert Boyd 6740 Roberts Avenue*

18. CAUSE OF DEATH (Enter only one cause per line)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Myocarditis (chronic)*

DUE TO (b)

*Asthma - (chronic)*

DUE TO (c)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.  
☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY  
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from *Dec 12 -61* to *Oct 14 -62* and last saw her/him alive on *Oct 2 -62*

Death occurred at *4:50* A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

*C. E. Sterling M.D.*

22b. ADDRESS

*8105 Page, St. Louis 30 Mo*

22c. DATE SIGNED

*10-18-62*

23a. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

23b. DATE

*10/20/62*

23c. NAME OF CEMETERY OR CREMATORY

*Lake Charles Cemetery*

23d. LOCATION (City, town, or county)

*St. Louis County Missouri*

(State)

24. FUNERAL DIRECTOR

ADDRESS

*Shepard Funeral Home, 1167 Hamilton Ave*

25. DATE RECD. BY LOCAL REG.

*10-18-62*

26. REGISTRAR'S SIGNATURE

*John B. Murphy M.D.*

USE BLACK INK  
OR  
TYPEWRITER RIBBON

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me.

working under my personal supervision.

Signed

P. O. Address Berkeley, 74

If this body is not embalmed, fact should be so stated above.